Patients treated in this way frequently require revision of the mobile areas of the face. But the revisions are minor procedures and well tolerated by the patient and family. The large facial blocks, such as forehead and cheeks, do not require late reconstruction.

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Breast Implants and Cancer Detection

THE MODERN SILICONE BREAST IMPLANT was first introduced in 1963, and since then well over 2 million women in the United States (1 in 33 between the ages of 20 and 60) have had their breasts enlarged or reconstructed using this device. Uncounted more have received silicone injections for the same purpose—a procedure that has fortunately fallen into disrepute. As the median age for implantation is 32, a substantial number of women are approaching, or are well into, the cancer risk age group, thus representing a significant public health issue.

Self-detection and physical examination do not seem to be influenced by the presence of an implant. Because the silicone is radiopaque, however, mammography reliability can be diminished. Breast tissue can be hidden by the implant or compressed to a density that obscures subtle lesions.

New technology is now available by which the breast can be pulled or pinched in front of the implant, substantially improving the quality of the image and the amount of tissue viewed. This, combined with extra tangential views of obscured areas, can produce high-quality, diagnostically reliable mammograms. If a firm capsular contracture is present, this technique may not be as effective.

Are women who have had breast augmentation at risk for a delayed detection of cancer? Certainly they are theoretically at risk, and every woman should be so advised. Thus far, however, there have been no substantiated reports in the medical literature of any woman whose cancer detection was delayed because of an inability to recognize early tumors by mammography. In a study of 3,111 Los Angeles women, no delay in the detection of cancer, even with pre-"pinch" technology mammography, was found. Thus the risk, while real, would appear to be slight. The table compares these patients with all age-matched Los Angeles women without augmentation.

The American Society of Plastic Surgeons and the Society for Breast Imaging have recommended the following cancer screening program:

- *Examination.* Follow the American Cancer Society recommendations for monthly self-inspection. Annual physical examinations by physicians with experience in examining augmented breasts should be routine.
- *Mammography.* Preoperative mammograms should be obtained for women older than 35 years, every one to two years for women aged 40 to 50, and annually thereafter. High-volume screening clinics in which two quick views are taken should not be used. Mammography should be done in the same center each year by qualified mammographers who will make an effort to tailor the test to each woman. While these diagnostic studies are more expensive, the low-cost screens can be unreliable and therefore worthless.

TABLE 1.—*Breast Cancer Stage Distribution*

Cancer Type	All Patients in Los Angeles County, %	Implant Patients in Los Angeles County, %
In situ	7.1	12.5
Local	50.2	50.0
Nonlocal	42.7	37.5

Women who have had silicone injections become impossible to examine because the silicone often forms multiple granulomatous masses, and mammograms are unreadable. These women have given up forever the ability to detect carcinoma before it has spread beyond the breast. Subcutaneous mastectomy and reconstruction should be seriously considered in this population.

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Melanoma Update

MALIGNANT MELANOMA should no longer be considered rare. With sunlight exposure as a proven etiologic factor, its rate of increase is exceeded only by that of bronchogenic carcinoma. The median age continues to be younger than 50 years and, like other neoplastic disease, melanoma is curable if detected at an early stage.

The most effective treatment of the early stages of melanoma continues to be surgical extirpation. It plays a primary role in the management of patients with stage I disease (primary melanoma) and stage II disease (recurrence of tumor in the local regional area) and a limited role in the treatment of stage III (distant metastases). Thin (< 1 mm) lesions can be cured with narrow margins (1 cm), whereas thicker lesions require 2- to 5-cm margins to decrease the risk of local recurrence. Solitary metastases to the brain, subcutaneous areas, or even lymph nodes may be suited for extirpation with a reasonably good prognosis.

The role of lymph node dissection is controversial, although data suggest a prolonged survivorship in patients with intermediate-thickness (1.5 to 4 mm) melanoma who undergo such operations. Surgical extirpation is also important in the palliation of extranodal extension to prevent the breakdown of overlying skin and soft tissues. Radiation therapy continues to be mainly palliative, especially with bony metastases.

Dacarbazine (DTIC) has been the most extensively used chemotherapeutic agent. When used as a single agent, this mode of therapy can produce response rates of 15% to 20%, largely in controlling soft tissue disease. Complete remissions are few (less than 5%) in most series.

Biologic therapy with interferon has produced responses in as high as 22% of patients with disseminated malignant